Enrollment Application/Change/Cancellation Request

UnitedHealthcare®
A UnitedHealth Group Company

☐ **Enroll**
☐ **Cancel**
☐ **Change**

☐ **Address Change**
☐ **Name Change**
Date of Change____ /___ /____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation Medical ______ Vision ______ Dental ______ Life ______	**Reporting Code** Medical ______ Vision ______ Dental ______ Life ______	**Benefit Level/Class Code, if applicable** Life/AD&D ______ Suppl. Life ______ Spouse Life ______ Suppl. AD&D ______

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___ /___ /___ Requested Date of Coverage ___ /___ /___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) ____________________
☐ COBRA/State Continuation start date _______ stop date________
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___ /__ /___

☐ **Cancellations:** Last Date of Employment ___ /___ /___
Requested Effective Date of Cancellation ___ /___ /___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached student/dependent max age
☐ Other (describe)____________________

Employee Type ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retire Date ______ ☐ COBRA/State Cont.

Signature ____ Date _______________

Employer Position_________________________ Phone Number____________________

A. Employee Information

Last Name	First Name	MI	Social Security Number	Home Phone Work Phone

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth / /	Sex ☐ M ☐ F	Physician* (First & Last Name) / Physician's ID Number	Primary Care Dentist Number*

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Race – Check all that apply (Optional)** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ________________

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Kentucky, L.P.
Dental coverage provided by United HealthCare Insurance Company, Unimerica Insurance Company, or Dental Benefit Providers of Illinois, Inc.
Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

United HealthCare of Kentucky, L.P.
2424 Harrodsburg Road, Suite 300
Lexington, KY 40503

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name First Name MI Social Security Number	Sex	Relationship**	Birthdate	Full Time Student***	Physician*(First and Last Name) Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change	 – –	M F	Spouse			
Race – Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____________						Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	 – –	M F	Dependent		☐ Yes ☐ No	
Race – Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____________						Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	 – –	M F	Dependent		☐ Yes ☐ No	
Race – Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____________						Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	 – –	M F	Dependent		☐ Yes ☐ No	
Race – Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____________						Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change	 – –	M F	Dependent		☐ Yes ☐ No	
Race – Check all that apply (Optional)**** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ____________						Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Please see employer representative for student status qualifications.

**** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $__________	☐	☐	☐	☐	
Spouse	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐					
				Salary __________ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address	Relationship

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier ____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date ____________ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date ____________ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date ____________ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: ______________________________________

☐ Enrolled in Part A: Effective Date ____________ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date ____________ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date ____________ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:

☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:

☐ Spouse's Employer's Plan
☐ Covered by Medicare
☐ COBRA from Prior Employer
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other ______________________________
☐ Individual Plan
☐ Medicaid
☐ VA Eligibility

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other ____________________________

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.